

DENTCARE

DELIVERY SYSTEMS, INC.
ATLANTIS GROUP APPLICATION

EMPLOYER INFORMATION

Company Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____ Title _____ Phone _____

Group Enrollment Census _____ = Single _____ Two Party _____ Family _____

Requested Effective Date _____ / 01 / _____

Has your company ever had dental coverage with Healthplex Insurance Company, Dentcare Delivery Systems, Inc. or International Healthcare Services, Inc. ?

YES NO

PLEASE SELECT A PLAN:

<input type="checkbox"/> CAPDENT	
_____ Groups of 1*	
Single	\$159.00/year
2-Party	\$264.00/year
Family	\$350.00/year
_____ 2-Tier	
Single	\$13.25/month
Family	\$28.00/month
_____ 3-Tier	
Single	\$13.25/month
2-Party	\$22.00/month
Family	\$30.00/month

<input type="checkbox"/> CAPDENT PLUS	
_____ Groups of 1*	
Single	\$264.00/year
2-Party	\$456.00/year
Family	\$660.00/year
_____ 2-Tier	
Single	\$22.00/month
Family	\$49.50/month
_____ 3-Tier	
Single	\$22.00/month
2-Party	\$38.00/month
Family	\$55.00/month

*** For groups of 1 person, the premium is annualized.**

1. There is an additional monthly premium of \$10.00 for each family member in excess of five (5).
2. Coverage for all dependents ends at age 19, or age 25, if full-time student.
3. Application, enrollment cards, and payment must be received by the 15th of the month for coverage to begin on the first of the next month. Exceptions will only be made if the application is received between the 15th and the 25th of the current month and payment is made by direct debit, certified check, money order, credit card, or wire transfer.
4. This application is subject to its acceptance in writing by Dentcare Delivery Systems, Inc.

For all remittances: **PLEASE SEE REVERSE SIDE**

Signature _____	Title _____	Date _____
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Broker/Agent: _____

Company: Atlantis Health Plan

Address: 39 Broadway, Suite 1240 **City:** New York **State:** NY **Zip:** 10006

Phone: _____ **S.S. # /Tax I.D. #** _____

Group # _____ **Sales Rep:** _____

PAYMENT OPTIONS

OPTION 1: DIRECT DEBIT

Routing Number:

Financial Institution _____

Name on Account _____

Account Number:

Checking

Savings

(Check One)

Note: because of processing time (30 days) 1st payment must be made by check

OPTION 2: CREDIT CARD

() VISA or () MASTERCARD

Name on Card _____

Card Number _____ Expiration Date _____

OPTION 3: CHECK

() Check enclosed in the amount of \$ _____ payable to **Dentcare Delivery Systems, Inc.**

MAIL TO: Dentcare Delivery Systems, Inc., 333 Earle Ovington Blvd., Ste 300, Uniondale, NY 11553-3608

To enroll on the 1st day of a given month, enrollment materials must be received by the 15th day of the preceding month. Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

I authorize Dentcare Delivery Systems, Inc. to either debit the above referenced account or charge the above-referenced credit card for my premium due. I understand the payment will be made by the 1st business day of each billing cycle.

Monthly

Semi-Annual

Quarterly

Annual

In the amount of \$ _____

Authorized Signature _____

Please Print Name _____

Title _____ Date _____

DENTAL PLAN ENROLLMENT FORM

FOR DENTAL PLANS BY DENTCARE DELIVERY SYSTEMS, INC., INTERNATIONAL HEALTHCARE SERVICES, INC., HEALTHPLEX INS. COMPANY, OR HEALTHPLEX, INC.

Last Name First Name M.I. Social Security #
Address Date of Birth
City, State, Zip Home Telephone

Employer Name / Group (if any) Group # Office Telephone
Date of Hire

GENDER: M F COVERAGE SELECTED: SINGLE HUSBAND & WIFE / PARENT & CHILD FAMILY / PARENT & CHILDREN

OTHER DENTAL COVERAGE: NO YES NAME OF OTHER PLAN (if any):

PLAN SELECTION: CAPDENT- INDIVIDUAL (may be subject to early cancellation fee)
STANDARD GROUP PLAN CAPDENT-GROUP CAPDENT PLUS-GROUP CAPDENT PLUS ULTRA-GROUP
Managed Care Option COMPREHENSIVE VOLUNTARY LOW MEDIUM HIGH
HIGH ENHANCED (check one) Reimbursement Option
PREFERRED PLAN - GROUP OMNI PLAN - GROUP HEALTHPLEX
INSURANCE COMPANY PLAN

DENTIST SELECTION (FOR MANAGED CARE OPTION): DENTIST SITE CODE:

DEPENDENTS TO BE COVERED (Spouse & unmarried dependent children)

Table with columns: Last Name, First, M.I., Dtr, Birth Date, M/F, Spse, Son. Contains 5 rows of data.

Agent Name (if applicable):
Agent Tax ID #:

I agree to maintain my enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a twelve month period.

SIGNATURE DATE EFFECTIVE DATE

F-2206 Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties. Print 1/07

DENTAL PLAN ENROLLMENT FORM

FOR DENTAL PLANS BY DENTCARE DELIVERY SYSTEMS, INC., INTERNATIONAL HEALTHCARE SERVICES, INC., HEALTHPLEX INS. COMPANY, OR HEALTHPLEX, INC.

Last Name First Name M.I. Social Security #
Address Date of Birth
City, State, Zip Home Telephone

Employer Name / Group (if any) Group # Office Telephone
Date of Hire

GENDER: M F COVERAGE SELECTED: SINGLE HUSBAND & WIFE / PARENT & CHILD FAMILY / PARENT & CHILDREN

OTHER DENTAL COVERAGE: NO YES NAME OF OTHER PLAN (if any):

PLAN SELECTION: CAPDENT- INDIVIDUAL (may be subject to early cancellation fee)
STANDARD GROUP PLAN CAPDENT-GROUP CAPDENT PLUS-GROUP CAPDENT PLUS ULTRA-GROUP
Managed Care Option COMPREHENSIVE VOLUNTARY LOW MEDIUM HIGH
HIGH ENHANCED (check one) Reimbursement Option
PREFERRED PLAN - GROUP OMNI PLAN - GROUP HEALTHPLEX INSURANCE
COMPANY PLAN

DEPENDENTS TO BE COVERED (Spouse & unmarried dependent children)

Dtr	Last Name	Birth Date	First	M/F	Spse	M.I. Son
						/ /
						/ /
						/ /
						/ /
						/ /
						/ /

Agent Name (if applicable):

Agent Tax ID #:

I agree to maintain my enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a twelve month period.

SIGNATURE _____ **DATE** _____ **EFFECTIVE** _____

DATE _____ Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties. Print 1/07

FREQUENTLY ASKED QUESTIONS

Q. How do I enroll?

A. First, review the Directory of Participating Dentists and select a provider that is conveniently located for you and your family (all family members must use the same dentist). Then, complete the enrollment form and enter the name and site number of your dentist. The form must be sent to Healthplex along with your check or credit card payment.

Q. Will I be satisfied with the services of my participating dentist?

A. We guarantee it! All of the dentists in our network have been credentialed by Healthplex, a Credentials Verification Organization certified by the National Committee on Quality Assurance* in 10 out of 10 credentialing elements. We also conduct site visits to make sure that all offices are well equipped, adequately staffed and are following proper sterilization techniques. If any Dentcare enrollee has a problem with his/her dentist, we will rectify the situation or refund the premium.

Q. How do I schedule an appointment?

A. Simply call your participating dentist after you receive your ID card and identify yourself as a CapDent Plan enrollee. Visits for routine dental care will be scheduled within a few weeks of your initial phone call. If you have a dental emergency, you will be given an appointment within 24 hours. Should you be away from home with a dental problem, you will be reimbursed up to \$50 for emergency care only.

Q. What expenses will I have in this plan for general dentistry and specialty care?

A. Your costs are clearly noted in the "Patient Copayment" column of the Schedule of Benefits. Services marked "No Charge" are rendered with no out-of-pocket expense. Other services have dollar amounts that you pay directly to your participating dentist when the treatment is provided. If you are referred to a participating endodontist, periodontist, oral

surgeon, or orthodontist your copayments will be 25% less than the specialist's usual fees. Referral Forms are not necessary when visiting CapDent participating specialists. Simply present your CapDent identification card to verify your enrollment.

For other questions about the plan, please call our Customer Service Department at:

800-468-0600

** The National Committee for Quality Assurance is an independent, non-profit organization that certifies credentials verification organizations and accredits managed care organizations.*

EXCLUSIONS AND LIMITATIONS

The following exclusions apply to all Dentcare plans:

1. Any dental services which were not rendered or approved by a participating dentist except in cases of out-of-area dental emergency.
2. A service not furnished by a Dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist.
3. Treatment of a disease, defect, or injury covered by a major medical plan, Worker's Compensation Law, occupational disease law, or similar legislation.
4. General anesthesia, or analgesia for general services rendered in a hospital environment.
5. Any dental procedures which are undertaken primarily for cosmetic reasons (including composite fillings of back teeth), or dental care to treat accidental injuries, congenital or developmental malformations.
6. Restorations, crowns or fixed prosthetics when acceptable results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the Plan will allow for the least costly alternative and the patient is responsible for all additional fees charged by the dentist.
7. Services which were started prior to the person becoming covered under this plan.
8. Implants, grafts, precision attachments or other personalized restorations or specialized techniques.
9. Broken Appointments - If specified by Plan Dentist for appointments not canceled 24 hours in advance, there is a \$30.00 charge.
10. Replacement of an existing crown, bridge or denture which can be made serviceable according to common dental standards.
11. Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth, or restore occlusion.
12. Treatment of unmanageable children and/or unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with

either the patient or with the parents of the patient.
13. Services not listed in the Schedule of Benefits are not covered.

The following limitations apply to all Dentcare dental plans:

Oral exams, bitewing x-rays, prophylaxes, scalings and fluoride treatments-Once every 6 mos.

Full mouth and panoramic x-rays -Once every 36 mos.

Crowns, bridges, dentures & periodontal surgery -

Once every 60 mos.

Orthodontic treatment of Class II/Class III malocclusions-

One 24 month case.

Under family coverage, children are covered to age 19 (25 if full-time students).



333 Earle Ovington Blvd.
Suite 300
Uniondale, NY 11553-3608

Customer Service
(800) 468-0600, Press Option 1

Plan Administered by:



www.dentcaredeliverysystems.org
www.healthplex.com

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03/07
GCDCY

Print

THE CAPDENT DENTAL PLAN

*For Groups and Individuals
Utilizing*

The CapDent Provider Network



Underwritten by:

THE CAPDENT DENTAL PLAN

This CapDent managed care program offers comprehensive dental benefits on a voluntary basis to individuals or groups who do not have access to a dental plan. Coverage is underwritten by Dentcare Delivery Systems, Inc., licensed by the New York Insurance Department

The CapDent Plan is different than conventional dental programs that include deductibles, maximums and other features that increase your out-of-pocket expenses. Instead of reimbursing you for dental services after you have received treatment, this plan actually provides the services that are covered through a network of participating dentists. There are no claim forms, lengthy predeterminations or waiting periods to cover pre-existing conditions. All of the benefits are available to you the day you enroll!

While the CapDent Plan includes all types of services including crowns, bridges, dentures, root canals, periodontal care and orthodontics, it stresses preventive and diagnostic dental services. Cleanings, exams, x-rays and fluoride treatments are all covered without any cost to the enrollee. This "preventive incentive" is important because dental disease can be greatly reduced with regular visits to the dentist. And if regular visits for preventive and diagnostic care are free, major dental work and its high costs can be minimized.

In this managed care program, you and your covered family members select a dentist from the CapDent Directory of Participating Providers and receive all treatment from that dentist. Some services are rendered without

any cost - others have a minimal copayment that you pay directly to the dentist. The schedule on the right lists all of the benefits and the applicable copayments. Should you require the care of a specialist, you may be treated by any CapDent participating endodontist, periodontist, oral surgeon or orthodontist. In such cases, your copayment will be different than the amounts shown on the Schedule. Services rendered by a participating specialist will be charged to you at 25% less than usual fees. Referral forms are not necessary.

SCHEDULE OF BENEFITS

* When a participating specialist renders these services, the copayment will be 25% less than specialist's usual fees.

PROCEDURE

PATIENT COPAYMENT

Diagnostic & Preventive Services

Oral Exam	No Charge
Full Mouth X-rays.....	No Charge
Single Films	No Charge
Bitewing Series.....	No Charge
Oral Hygiene Instruction.....	No Charge
Cleaning of Teeth (polishing).....	No Charge
Fluoride Treatment.....	No Charge
Emergency Treatment.....	No Charge

Restorative Dentistry Primary and Permanent

Silver amalgam, one surface.....	\$20.00
Silver amalgam, two surfaces.....	35.00
Silver amalgam, three surfaces or more.....	50.00
Composite filling, one surface.....	25.00
Composite filling, two surfaces.....	40.00
Composite filling, three surfaces or more.....	55.00

***Oral Surgery**

Routine Extractions - per tooth.....	45.00
Surgical Extraction.....	75.00
Soft Tissue Impaction.....	95.00
Partial Bony Impaction.....	125.00
Full Bony Impaction.....	160.00
Alveolectomy, per quad.....	95.00

***Root Canal Therapy**

Pulp Capping.....	10.00
Pulpotomy.....	35.00
Root Canal Therapy- Anterior.....	225.00
Root Canal Therapy-Bicuspid.....	290.00
Root Canal Therapy-Molar.....	395.00
Apicoectomy.....	175.00

***Periodontics**

Scaling of teeth, per quad.....	25.00
Gingivectomy, per quad.....	125.00
Osseous surgery, per quad.....	425.00

Prosthetics - Crowns

Acrylic with metal crown.....	295.00
Porcelain crown.....	385.00
Porcelain w/ metal crown.....	425.00
Stainless steel crown.....	95.00
Cast post.....	95.00
Recementation, per crown.....	35.00

Prosthetics - Fixed Bridges

Acrylic w/ metal bridge crown or pontic	295.00
Porcelain w/ metal bridge crown or pontic.....	425.00
Recementation, bridge.....	35.00

Prosthetics - Removable

Full upper denture, inc. adjustments.....	395.00
Full lower denture, inc. adjustments.....	395.00
Partial upper denture, cast base and acrylic.....	395.00
Partial lower denture, cast base and acrylic.....	395.00
Denture Adjustments (for denture not made in office).....	35.00

Prosthetics - Repairs

Broken body of denture (no teeth involved).....	95.00
Replacing broken, missing teeth.....	35.00
Office Reline.....	95.00
Lab Reline.....	150.00

Orthodontics

Maximum Case Fee - 24 months.....	75% UCR
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WHY POINT-OF-SERVICE?

Because you told us what you wanted in dental benefits - affordability and choice. That's why we put both into this first-of-its-kind plan - CapDent Plus.

Sure to please purchasers as well as patients, the heart of this true point-of-service dental program is an affordable managed care plan using a network of participating dentists. Diagnostic and preventive services are covered in full, with minimal cost to patients for additional services. There are **no deductibles, no maximums and no waiting periods** for prosthetic treatment in-network. Out-of-pocket expenses are low and coverage is extensive.

What's innovative about CapDent Plus, however, is that managed care enrollees may also elect to use **any licensed dentist** of their choice - **at any time**. Patients who seek care out-of-network are reimbursed according to a schedule of benefits for covered procedures. While some deductibles and maximums may apply, "freedom of choice" means you get the care you want at a cost you can afford - the best of both worlds.

WHY DENTCARE?

Founded and managed by practicing dentists, Dentcare pioneered the introduction of managed care to dental benefit plans and is one of the largest independent dental benefit companies in the Northeast. This is our only business. As specialists in managed care and dental claims administration, we are uniquely qualified to design and administer innovative, high quality - low cost dental plans. In fact, the CapDent Plus program was the first true point-of-service dental plan to be offered in the New York Metropolitan area!

The plan is underwritten by Dentcare Delivery Systems, Inc. Dentcare is an Article 43 Insurance Company licensed by the New York State Insurance Department. The Plan is administered by Healthplex, Inc.

PLAN SPECIFICATIONS

OUT-OF-NETWORK:

- Coverage is available at any dental office.
- Deductible of \$40.00 per person (not applicable to Diagnostic and Preventive Services).
- Maximum benefit of \$1200.00 per person per contract year for general dentistry and \$720.00 per person (lifetime) for Orthodontic treatment.
- Allowances for Basic and Major Services will be paid to the enrollee or can be assigned to the dentist. Patients are responsible to their own dentist for all charges not covered by the Plan.
- There is a waiting period of 12 months for prosthetic benefits (other than single crowns) and 24 months for orthodontic coverage.
- Predetermination of Benefits is suggested for treatment plans in excess of \$500.00.
- Services not listed are not covered.

IN-NETWORK:

1. Coverage is available only at the offices of participating general dentists and specialists.
2. General dentists must be selected in advance from the list of CapDent/CapDent Plus general dentists. All family members must go to the same general dentist.
3. No deductibles, no maximums, no claim forms and no waiting periods for prosthetics.
4. Diagnostic and Preventive Services are covered in full.
5. Basic and Major Services have fixed copayments that are paid by the patients directly to their participating General dentists.

6. If the services of a specialist are required you will be charged directly by the specialist at a discount of 25% less than usual fees. No referral forms are necessary.
7. There is a \$5.00 fee for each visit to participating dentists.
8. Services not listed (including cosmetic treatments) are covered with a copayment of 25% less than the participating dentists usual fees.

**EMERGENCY REFERRAL
24 HOUR SERVICES
(800) 468-0600**

SCHEDULE OF BENEFITS - CAPDENT PLUS

OUT-OF-NETWORK: These are the amounts that the plan will pay for the services listed.
IN-NETWORK: These fees are the most you will pay to your CapDent participating dentist for the services listed.

	OUT-OF-NETWORK Reimbursement Schedule	IN-NETWORK Patient Copayment \$5 Per Visit Fee Per
Person		
Diagnostic & Preventive Services		
Oral Exam	\$16.50	No Charge
Full Mouth X-rays	38.50	No Charge
Periapical, 1st Film	5.00	No Charge
Panorex X-ray	27.50	No Charge
Cleaning (polishing) Child/Adult	27.50	No Charge
Fluoride Treatment, to age 16	16.50	No Charge
Emergency Treatment	22.00	No Charge
Restorative		
Sealants, Per Tooth	16.50	\$20.00
Silver amalgam, one surface	22.00	No Charge
Silver amalgam, two surfaces	33.00	No Charge
Silver amalgam, three surfaces or more	44.00	No Charge
Composite filling, one surface	22.00	No Charge
Composite filling, two surface	33.00	No Charge
Composite filling, three or more surfaces	44.00	No Charge
Pin Retention	11.00	No Charge
Oral Surgery		
Routine Extraction	38.50	25.00 ¹
Surgical Extraction	50.00	50.00 ¹
Soft Tissue Impaction	65.00	50.00 ¹
Partial Bony/Full Impaction	100.00/135.00	75.00/100.00 ¹
Alveolectomy, per quad	65.00	50.00 ¹
Root Canal Therapy		
Pulp Capping, direct	11.00	No Charge ¹
Pulpotomy	32.00	No Charge ¹
Root Canal Therapy - Anterior	215.00	125.00 ¹
Root Canal Therapy - Bicuspid	250.00	190.00 ¹
Root Canal Therapy - Molar	300.00	335.00 ¹
Apicoectomy	110.00	125.00 ¹
Periodontics (over 18 years of age)		
Scaling of teeth, full mouth	32.00	45.00 ¹
Gingivectomy, per quad	80.00	95.00 ¹
Osseous surgery, per quad	135.00	350.00 ¹
Prosthetics - Fixed, Removable		
Acrylic with Metal Crown	160.00	150.00
Porcelain Crown	160.00	270.00
Porcelain with Metal Crown	215.00	270.00
Full Cast Crown	160.00	150.00
Porcelain Laminates	135.00	270.00
Stainless Steel Crown	55.00	50.00

Post.....	55.00	.....	50.00
Recementation, per crown.....	17.00	.....	No Charge
Acrylic w/Metal Bridge Crown or Pontic.....	160.00	²	150.00
Porcelain w/Metal Bridge Crown or Pontic.....	215.00	²	270.00
Full Cast Metal Bridge Crown or Pontic.....	160.00	²	150.00
Resin Retainer.....	135.00	²	220.00
Recementation, bridge.....	17.00	.....	No Charge
Full upper or lower denture, inc. adjustments.....	275.00	²	295.00
Partial upper or lower denture, cast base.....	305.00	²	295.00
Denture Repairs.....	12.00 - 55.00	.....	25.00 - 75.00
Office Reline.....	40.00	.....	50.00
Lab Reline.....	82.00	.....	95.00
Orthodontics			
Case Fee - 24 months	\$30.00/month	³	75% UCR ¹

¹ **Copayments for these services when rendered by a participating specialist will be 25% less than the dentists usual fees.**

² Subject to a 12 month waiting period (other than for single crowns).

³ Subject to a 24 month waiting period and a lifetime maximum of \$720.

B-3421

HOW TO ENROLL?

Be sure you understand all the benefits available under each CapDent option before filling out your application. Remember that the in-network benefits shown are *payments that you will make* directly to your participating dentist for services rendered. Out-of-network amounts shown are *allowances that you will receive* towards the costs of the procedures indicated. Both plans are subject to the exclusions and limitations noted in this brochure.

Once you have carefully read the information, fill out an enrollment form. Be sure to enter the name of a participating general dentist if you wish to receive treatment within the network. As soon as your enrollment form is received and the information entered in our system, your identification card with the effective date of coverage, will be on its way to you.

When you require dental care, simply call your CapDent participating general dentist, identify yourself as a plan enrollee and make an appointment. This dentist will charge all treatment according to the in-network plan benefits. **If you require specialty treatment, you may use any participating Specialist or you may use your own specialist. Work performed by a participating Specialist will be charged directly to the patient at a discount of 25% from Usual and Customary fees.** If you prefer to visit your own dentist or specialist and receive out-of-network benefits, it's just as easy. Make your appointment and submit claim forms to Healthplex at the address shown on the front of this brochure. You will then be reimbursed according to the out-of-network schedule in this brochure.

Groups or enrollees who terminate from the plan in less than one year may be reinstated, solely at the discretion of Dentcare. If allowed, an annual billing mode may be required.

EMERGENCY CARE (IN-NETWORK)

In general, two emergency visits to a participating dentist per calendar year are

covered under this option. However, if you are undergoing treatment and have had regular checkups, there is no emergency visit limit. If you are unable to reach your plan dentist, you can call our 24 hour emergency telephone number (800-468-0600) to obtain immediate care from another local participating dentist. If the emergency is out-of-area, or you are unable to obtain the services of a plan dentist, you will be reimbursed up to a maximum of \$50 per family member per calendar year for emergency treatment. In order to receive this payment you must submit a bill to Healthplex for emergency care rendered by a non-participating dentist.

EXCLUSIONS

1. Any dental services which were not rendered, prescribed, arranged, or approved by a plan dentist, except in cases of out-of-area dental emergency (In-Network Plan).
2. A service not furnished by a Dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist.
3. Treatment of a disease, defect, or injury covered by Workmen's Compensation Law, occupational disease law, or similar legislation.
4. General anesthesia or anesthesia for general services rendered in a hospital environment.
5. Any dental procedures which are undertaken primarily for cosmetic reasons (including composite fillings on back teeth), or dental care to treat accidental injuries, congenital or developmental malformation.
6. Restorations, crowns or fixed prosthetics when acceptable results can be achieved by alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the Plan will allow for the least costly alternative, and the patient is responsible for all additional fees charged by the dentist.

7. Services which were started prior to the person becoming covered under this plan.
8. Implants, grafts, precision attachments or other personalized restorations or specialized techniques.
9. Broken appointments - If specified by Plan Dentist, for appointments not canceled 24 hours in advance, there is a \$30.00 charge.
10. Replacement of any existing crown, bridge or denture which can be made serviceable according to common dental standards.
11. Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth, or restore occlusion.
12. Treatment of unmanageable children and/or unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents of the patient (In-Network Plan).
13. Services not listed in the Schedule of Benefits are not covered.

LIMITATIONS

The following limitations apply to all Dentcare plans:

Oral exams, bitewings x-rays, prophylaxes, scalings, fluoride treatments - Once every 6 months

Full mouth x-rays, crowns, bridges, dentures, periodontal surgery - Once every 60 months

Periodontal Services - Covered for enrollees 18 years of age or older.

Orthodontic treatment of Class II/Class III malocclusions - One 24 month case.

Under family coverage, children are covered to age 19 (25 if full-time students).

Certain other procedures may have age or time limitations. A list of such services is available on request.

This is not a summary plan description designed to meet the requirements of ERISA. This brochure contains a general description of your Dental Care Program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract.

CapDent Plus

A POINT OF SERVICE
DENTAL PLAN

Underwritten by



Plan Administered By:



333 Earle Ovington Blvd.
Suite 300
Uniondale, NY 11553-3608

Customer Service
(800) 468-0600, Press Option 1

www.healthplex.com

www.dentcaredeliverysystems.org